Authorization/Denial to Obtain or Release Information and Records

Attention: _____

Resident Name: _____ D.O.B.: _____

OBTAIN: I, _____(Resident/Guardian if resident is a minor) authorize _____ (Name of program) by fax or mail, to obtain information including medical and/or mental health records from:

(Name and telephone number of agency/school/physician)

(Complete mailing address of agency/school/physician)

RELEASE: I, _____(Resident /Guardian if Resident is a minor) authorize _____ (Name of program) via U.S. mail, to release information including medical and/or mental health records to:

(Name and telephone number of agency/school/physician)

(Complete mailing address of agency/school/physician)

Dates of service: _____ (Fill in only if limiting the dates of records, otherwise complete record will be sent.)

Please indicate the SPECIFIC information to be disclosed: (please complete each category)

Y	N	Intake Assessment Summary (Clinical Interview)	Y	N	Progress Notes
Y	N	Service Plans	Y	N	Discharge Summary
Y	N	Medical Summaries	Y	N	Psychiatric Summaries and medications
Y	N	School Information	Y	N	Other _____

The purpose of this release of information is:

_____Assist in service planning _____ Coordination of care _____ Evaluation

_____Other (specify) _____

(signature required on next page)

CERTAIN PROTECTED CATEGORIES OF INFORMATION CANNOT BE RELEASED UNLESS THE NEXT PAGE OF THIS FORM IS COMPLETED.

I understand that this authorization is subject to revocation at any time, with written notice by the resident or other responsible party. The consent will last no longer than three months after services end.

Signature of Resident (Parent/Guardian if resident is minor) Date

I do NOT authorize _____ (Name of program) to release information to or obtain information from: _____

(Name of agency/school/physician)

Signature of Resident (Parent/Guardian if resident is minor) Date

PROTECTED INFORMATION

Your signature on the above portion of this sheet does not pertain to the categories listed below. Information in these protected categories will not be released from your record without your signature on this page or a court order. The authorization to release information pertaining to these protected categories is only valid for (check one):

____ 30 days ____ 60 days ____ 90 days ____ 90 days after termination

____ Other: _____

INITIAL ONLY THE CATEGORIES OR INFORMATION YOU WISH _____ (Name of program) TO RELEASE:

____ Alcohol Abuse ____ AIDS ____Domestic Violence ____Mental Health

____ Drug Abuse ____ HIV Testing ____ Sexually Transmitted Disease

____ Hepatitis B Testing/Treatment ____ Hepatitis C Testing/Treatment ____ Other: _____

I understand that I have the right to inspect and copy the information to be disclosed, and that I may withdraw this Authorization at any time except to the extent that action has been taken in reliance upon it. I understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

Signature of Resident (or Parent/Guardian, if resident is a minor) Date